



Lafon
Cushing
Grey

Wier
Baker
Howard
Smilie

Luger
Goelch
Christen
Elli

Burlingham
Chester
Dawson

Megeath

In Celebration of the 25th Anniversary of the Admission
of the First Patient to the Medical Service of the
Peter Bent Brigham Hospital on March 31st, 1938.

Dr. Christian

IT seemed to me that it would be nice if we had a family party to celebrate the twenty-fifth anniversary of the admission of the first patients to the Medical Service.

Exactly 25 years ago, on March thirty-first, nine patients were admitted to the Medical Service through the Front Office, which was presided over by Dr. Burlingham. Dr. Burlingham is at present Superintendent of the Barnes Hospital at St. Louis.

I am going to ask you to take yourselves back 25 years and picture this procession, not very long, of nine patients coming down the "Pike" on their way to Ward F. They represented very much the type of patient we have today. Two of them were Jewish; one was a widowed negress; another a Canadian Scotchman; two were Irish and two were New England Yankee spinsters. Those are the almost extinct species of today—not the spinsters but the Yankees.

They represented a variety of diseases much as we have today. Two were cases of nephritis, two were cardiacs without valvular disease, two had tumors, one had alcoholic neuritis, one was a syphilitic case and that is of historical interest because at that time patients with syphilis were not admitted to any large general hospital in Boston. This was the first hospital in Boston to take into a general service patients with syphilis or tuberculosis. It happens that there were no cases of tuber-

culosis in this group. One of these patients is still alive and she came in at the age of 50 with hysterical hiccoughing. She has hiccoughed periodically ever since. The last time she hiccoughed herself into the hospital was on Sept. 12, 1932, and I have reason to believe that she may still be hiccoughing at home, not all the time, but just when she feels like it.

Now, we have here today all the original medical staff except the late lamented Dr. Francis Peabody, who meant so much to us in the early days of organization and whose spirit has expressed itself in the subsequent years, as he expressed himself in those early days when he was our resident physician.

I will now introduce the staff: Dr. Frothingham, who was physician at that time; Dr. Walker, who was an assistant resident physician; Dr. Fitz, house officer in charge of the Out-Door Department; Dr. Dawson, who was senior house officer on the ward; Dr. Smillie, junior on the ward and Dr. Sisson, who was "pup"; and then very important, Miss Frances Burnham (Myles), who was our head nurse on Ward F. At that time Ward F-main was the only ward open and part of it was occupied by the male and part of it by the female patients under the supervision of Miss Burnham.

Next I will introduce Patient No. 1, M. P. We will have the history of patient No. 1 by Dr. Dawson, who took the history 25 years ago.

Dr. Dawson

The patient was 42 years old, a Jewish widower, brass polisher, born in Russia. He was admitted with the chief complaint of cough and shortness of breath. His present story dated back eight weeks; apparently its onset was acute. He started for work in the morning in his usual good health. He returned home at night complaining of cough, chills, fever and general feeling of malaise. He called in his local doctor who told him that he had the grippe and put him to bed where he remained for three weeks. During these three weeks he continued to have cough and a moderate amount of sputum. Sputum never contained blood. There was no chest pain. At the end of three weeks he was allowed out of bed, continuing to cough, feeling very weak. Two weeks before admission to this hospital he visited the O. P. D. of the Massachusetts General Hospital and I note that no urine examination was made because he was unable to void. The next notation is that a week before entrance he visited the Boston Dispensary and he was unable to void on that visit. The next day he returned with urine frankly bloody. This was the first time that he had noticed any abnormality of the urine. The Boston Dispensary referred him to us. He continued to pass small amounts of bloody urine until admission. There was no difficulty in voiding, no smarting or burning but small amounts of urine were passed frequently. During the week prior to admission his cough had gradually diminished. He complained of some pain and a sense of pressure or compression in the left upper abdomen. During the eight weeks that covered his history he had lost thirty pounds.

On physical examination we found a man lying comfortably in bed with slight unproductive cough. He gave evidence of having lost a good deal of weight. The skin was noted as dry, loose, without evidence of jaundice. The chest was symmetrical, and moved equally on both sides. The heart was not enlarged. There were

no murmurs. The blood pressure was 118 systolic; there was no record of the diastolic reading. I think we did not know much or realize the importance of the diastolic pressure 25 years ago. The abdomen on inspection showed a protuberance in the left upper quadrant. This proved to be on palpation, a smooth, hard tumor, which moved with respiration, and was slightly tender on pressure. It was fairly large and extended well over to the right abdomen, not nodular. There was no fluid demonstrable in the abdomen. The liver was not enlarged.

Dr. Smillie

My observations of the patient were as follows: The patient was resting fairly comfortably and enjoyed his surroundings. We gave him the usual dose of magnesium sulphate that we gave to every patient who entered the hospital, and also ordered two A.S. & B. pills which were given every other day in addition to 15 grams of magnesium sulphate. He coughed a good deal during that night and we gave him codeine sulphate to relieve his cough.

Dr. Sisson

The urine was peculiarly cherry-red and often had a very syrupy consistency. Specific gravity was noted as practically normal between 1.015 and 1.029. There was a large trace of albumin. The sediment contained a great many red blood cells and white blood cells. There were a few granular casts. Special study was made of the urinary sediment for tubercle bacilli, none were found. The blood was essentially normal. The hemoglobin was about 80% (S). Differential showed 60% polymorphonuclears and about 32% lymphocytes. The smear was negative. Sputum was examined with considerable care and no tubercle bacilli found.

Dr. Christian

The next step in the study of this patient was to call in the aid of the Surgical Service, and Dr. Cheever carried out cysto-

scopic examination which I shall ask him to report.

Dr. Cheever

The conclusion reached tentatively from the cystoscopic examination was that the patient had a normal right kidney with normal excretion; a left kidney, whose excretion as shown by the 'phthalein test was very much decreased in amount, contained blood, a kidney therefore which must have been the seat of bleeding. The tentative diagnosis was hypernephroma with the reservation that of course it might be something else, like tuberculosis, inflammation of the kidney, calculus or pyonephrosis, subject to what the laboratory found. Mr. P. showed excellent morale and I think suffered no pain at all during the procedure.

Dr. Dawson

After eight days with us, we note that Dr. Christian expressed his opinion that the tumor in the left upper quadrant was undoubtedly of a malignant sort, but that we could not rule out tuberculosis. On that day he was discharged to the Surgical Service. He was operated upon by Dr. Cheever.

Dr. Cheever

Mr. P. continued to be an ideal patient and showed great courage. He was anesthetized with ether by the open drop method by Dr. Grey, our house officer, who placed the patient on the right side exposing the left flank. The skin was prepared by the iodine method, a long incision made from the lower border of the 12th rib to the crest of the ilium and then forward along the anterior superior spine. This was carried through muscles and peri-renal fat and the capsule of the tumor was exposed: "a moderate sized tumor, according to Brigham standards." Nevertheless after attempts to enucleate it, it became necessary to resect the 12th rib, to get more room. This was done by sub-periosteal dissection. The 12th nerve was

carefully preserved. Then in the liberation of the upper edge of the wound, in order to gain exposure, it became evident that the pleural sac had been torn a little because there was a to-and-fro discharge of air. This did not affect Mr. P.'s condition at all except that his respirations increased a little bit. The pedicle was developed and it was clamped with three clamps, two proximally and one distally. It was tied off with heavy black silk and all this was accomplished without opening the peritoneal cavity. The wound was then closed in layers with chromic catgut and a small protective rubber drain was inserted. The patient withstood the operation well.

Dr. Christian

Dr. Rhea who was the pathologist 25 years ago regrets very much that he could not be present. He is professor of Pathology at the Montreal General Hospital. Dr. Ayer, our present resident pathologist, will tell us now about the tumor Dr. Cheever removed.

Dr. Ayer

I will read the words of Dr. Rhea: "This specimen consists of a mass 20 cm. long, 12.5 cm. wide and 6 cm. thick. Roughly it is the shape of a kidney, the surfaces are irregular. The pelvis and ureter are greatly distended and filled with a thin reddish material. Beginning near the mid-portion of the mass there is an area 10 cm. long, 7.5 cm. thick and 7 cm. wide, which has a distinctly different character from the remainder of the specimen. Throughout this area there are distinct irregularities in the surface which give to it a nodular appearance. Some of these nodules are pale, but all of them show discrete and confluent yellowish areas which vary in size from 1 mm. up to 1 cm. in diameter. On section the nodular area is very soft, granular, reddish-yellow in color; the characteristics of a hypernephroma."

"Histological Report—The tumor is fairly definitely surrounded by a connective

tissue capsule, but in this capsule small areas of tumor are seen. It consists of a very cellular tissue in which are numerous dilated blood vessels and large blood lakes. The general structure is that of finger-like processes covered with rather large pale, edematous cells. Between these processes there is blood and eosin-staining coagulated material. The cells composing the tumor vary somewhat in their histological structure. Most of them are quite large, show a rather deeply staining nucleus with a pale, washed-out appearing cytoplasm. A few mitotic figures are present. There are areas in which the tumor cells show varying degrees of degeneration. The best preserved cells are those about the blood vessels. Diagnosis: Hypernephroma of kidney."

(Two slides of the original tumor were shown.)

The diagnosis 25 years ago was hypernephroma of the kidney, a term which included tumor of renal and adrenal origin. Since this tumor is one of renal origin, this diagnosis today is carcinoma of the kidney, clear cell type.

Dr. Christian

This patient was discharged from the hospital in good condition. He was sent for in January, 1915, and was examined by the surgical house officer, Dr. Cutler, who will now report on what he found.

Dr. Cutler

I saw this patient when I was a house officer in the O. D. D. on January 29, 1915, almost two years following removal of his tumor. Physical examination was perfectly negative, although unfortunately he could not pass his urine and it was not examined. He was again examined in October, was in good condition and no tumor was felt in his left flank. He had no particular complaint. His urine again was not examined. He turned up on July 2, 1919, at the Johns Hopkins Hospital, complaining of pain in his flank and dysuria. He was apparently quite carefully

studied. The urine was perfectly negative and he was discharged with the diagnosis of neurasthenia. On February 8, 1921, almost two years later, he was admitted to the Johns Hopkins Hospital in a serious condition. He had lost 80 pounds in weight. He complained of great pain in his flank and dysuria and was obviously a very sick man. On physical examination there was a large, sessile, nodular, palpable mass occupying the left flank and the left hypochondrium. The urine contained blood. After a week's study he was cystoscoped twice and the second time pyelograms were taken using thorium for the medium. The conclusion was that the patient had a recurrence of malignant tumor of his left kidney, totally inoperable. He was discharged without further treatment.

Dr. Christian

I think this illustrates very well that these patients 25 years ago were very thoroughly studied, very adequately treated and very carefully followed up. Just when P. died, we are not certain and we will give P. an opportunity to tell us when he did die and where he has been since.

(Dr. Quinby, posing as the patient, was wheeled in. He exclaimed that he was not dead and was enjoying his ride.)

Dr. Christian

Next I will introduce Patient No. 2.

Dr. Dawson

This patient was a Canadian Scotch box maker, 55 years of age, born in Canada. His chief complaint on entry was shortness of breath. Past history revealed that twenty-five years before entry he had typhoid fever. Many years before entry he had an abscessed tonsil. This was followed by several similar attacks during the following four years. The present story dated back four weeks. At that time he first noted that on ordinary effort he became short of breath. At the end of two weeks he had to give up his work, and he

began to experience stuffiness in his chest and precordium. During the last month he noticed a very definite gain in weight. For two weeks he had a very annoying cough, and some swelling of the ankles and lower legs.

On physical examination we found a man lying fairly comfortably in bed, except for some very obvious dyspnea. The pupils were small, and the left was irregular, possibly slightly larger than the right. Examination of the heart showed neither palpable nor visible apex beat. The left border of dullness was 11.5 cm. to the left of the midsternal line. The right border of dullness was 4 cm. to the right of the midsternal line. Sounds were described as distant and of poor quality. At the apex there was a very definite, sharp, moderate harsh systolic murmur. This murmur was easily heard in the axilla and in the left back. The systolic blood pressure is recorded at 178; again we have no record of the diastolic reading on that first entry. Examination of the lungs showed diffuse moist râles, most marked at both bases. The liver was felt 3 fingers below the costal margin. There was very definite pitting edema of the lower legs, ankles and sacrum.

Dr. Smillie

In contrast to the previous patient, this patient was given 30 grams of magnesium sulphate, and then 15 grams of magnesium sulphate every other day and two A.S.&B. pills every day. In addition to this customary routine there was written in the order book—no meat or meat soups. He was allowed milk and vegetables and given 0.09 gm. of digitalis, powdered leaves, three times a day.

Dr. Sisson

This patient's laboratory studies consisted of examination of the stools on three or four occasions which showed normal fecal material, guaiac positive on one of the three studies. The urine was clear, acid, with specific gravity of 1.020 to 1.025.

There was no sugar. The sediment contained a number of casts, granular and hyaline on one or two occasions. Occasional r.b.c. and w.b.c. were noted. The blood smear was regarded as normal. Hemoglobin 105%.

Dr. Christian

This patient was subsequently admitted to the hospital a year or so later but as long as he is here himself we will allow him to tell us about the second admission, his demise and his autopsy.

Dr. Levine (impersonating the patient)

I came back here a second time in 1914. The men were surprised to see me as I imagine they thought I was already in heaven. In fact, they will be surprised to know that after their excellent treatment, I carried on for ten years more and died in 1924. The doctors were a very scientific lot. When I improved on my first admission, they did not know whether I got better because of the excellent nursing care or those wonderful digitalis pills. The second time, therefore, they gave me none of those magic pills and I got worse and worse, but just as soon as I started the foxglove my breathing got better and I began to feel like a new man. It was one of the first proofs that was ever obtained anywhere that digitalis would help a heart when the beat was regular. Many people used to doubt this, and some do now, but the doctors at the Brigham have known it for many years. My autopsy showed that I had chronic myocarditis without any disease of the valves. Many doctors thought I had valvular disease but the two clever doctors at the Brigham, Fitz and Frothingham, knew better; they called it "relative mitral insufficiency" and they were right.

When I finally joined the merry crowd up in heaven, I started a Peter Bent Brigham Dinner Club. We used to meet every Saturday night and all people who ever were at the Brigham were members. Most of us would attend these meetings

except those who went to the movies and had dates. We used to discuss the autopsy findings in those cases that were not posted at the hospital. Occasionally we would have a laugh on the doctors down below when they missed something important but, on the whole, they were pretty good diagnosticians. We also had "grand rounds" and "petit rounds". The only difference between our rounds and the Professor's Saturday morning rounds was that the tables were turned; the patients now made the doctors the real goats and gave them an earful of what they had wrong with them. It took them a day or two to get over the effects of these rounds just as it did us in the old days.

We all up here keep an eye on you young men working at the Brigham to see that you carry on the good work that was started in our early days. You know that most of the early house officers became professors in later years; there was Dr. Fitz, Dr. Smillie, Dr. Peabody, Dr. Cutler, Dr. Blake, and even Dr. Allen Woods. He has become Professor of Ophthalmology at Hopkins. You see, you can become a professor in almost anything if you have just been a house officer at the Brigham. In fact even a surgical house officer may become a professor of medicine; that is what happened to Bill McCann who is now Medical Chief at the University of Rochester. You young boys must watch your step and work hard as they did in the early days of the hospital. You must keep the banner flying on high, and until the next big reunion, good luck and cheerio.

Dr. Christian

I want to introduce our first negro patient on the Medical Service. Dr. Dawson will tell us about S.

Dr. Dawson

S. was a 63-year old colored housewife. Her chief complaint was shortness of breath for one year, first noticed on doing ordinary housework. This gradually in-

creased so that ten months before entry she had to give up her usual household duties. Four months before entry she experienced what she described as a sense of stuffiness in the front of her chest. With this there was no pain. She had repeated similar attacks each lasting a short time. During the four months prior to entry she noticed nocturia four to six times. She had 11 children, full term, normal deliveries; no miscarriages. On entry we found her lying in bed, fairly comfortable. She had no dyspnea or cyanosis. She was a slight little woman who said that she had always been so. There was marked arcus senilis. Inspection showed that her chest was symmetrical, moved equally on both sides. Her heart showed a diffuse, easily palpable, forceful apex impulse. The left border of dullness was 16 cm. from the midsternal line. There were no substernal or cervical pulsations noted. Blood pressure on entry was 232 systolic. We found a harsh, musical, apical, systolic murmur, which was heard all over the precordium and very easily in the axilla and left back. There was also a localized, soft, systolic murmur in the second interspace to the right of the upper sternum. Both sounds in the second interspace were described as harsh and rasping. Radial arteries were markedly thickened and sclerosed. Examination of the lungs showed a few râles at both bases. The abdomen was negative. There was no edema. Examination of the eye grounds showed albuminuric retinitis.

Dr. O'Hare (impersonating the patient)

You forgot to say "Ah's sweating".

Dr. Smillie

This patient entered in the afternoon and that evening was given 15 mgm. of morphine sulphate. She was put on soft solids, with no meat or meat soups and no eggs and given magnesium sulphate 15 grams every other day. She had complained of pain in the chest and was given nitroglycerine .6 mgm. every four hours and

was started on diuretin 1 gram, three times a day. The following morning she complained of pain in her lower left side. She was given an S.S. enema with good results.

Dr. Sisson

The patient's urine contained a trace of albumin and the sediment showed many casts of all descriptions, granular and hyaline, and r.b.c. and w.b.c. very frequently. Specific gravity varied from 1.015 to 1.020. The blood studies showed a relatively high hemoglobin, 105% (S) (uncorrected). Smear showed 52% polymorphonuclears, 2% eosinophiles.

Dr. Christian

Dr. Walker had charge of the Wasserman Laboratory. I shall ask him to report on the patient's Wasserman reaction.

Dr. Walker

The Wasserman report was negative.

Dr. Christian

Then there were some special studies made by both Dr. Fitz and Dr. Smillie.

Dr. Fitz

I had just come back from Baltimore where I worked in Dr. Abel's laboratory with Drs. Rowntree and Geraghty. We attempted to study renal function in chronic Bright's disease, using particularly the phenolsulphonphthalein test. An injection of phenolsulphonphthalein was given to this patient and the result was a 14% excretion in 2 hours and 10 minutes. Experimentally, Dr. Rowntree and I found that chronic passive congestion might cause a lowered 'phthalein excretion. From a solitary test, therefore, in a given case it was impossible to say whether the lower renal function was due to a kidney damage or to a superadded chronic passive congestion.

Dr. Smillie

(Dr. Smillie demonstrated a tracing

showing relation of pulse and blood pressure to Cheyne-Stokes respiration.) During apnea the volume of the pulse was small and rapid, the rate being 60 in 30 seconds. During dyspnea the pulse became slower and fuller in volume, rate 48 in 30 seconds. The blood pressure fell during apnea until just at the end it reached 110. It rose rapidly however during dyspnea so that at the very height the blood pressure was 160, where it was sustained almost until the period of apnea began. The Cheyne-Stokes respiration was very regular, apnea lasting about 30 seconds, dyspnea about 30 seconds.

The patient died at 10.00 P. M. The tracings were taken that afternoon.

Dr. Christian

As it has been noted in the various histories, we began in the beginning of the hospital development to use the electric ophthalmoscope and I find in the notes of this patient that I made an ophthalmoscopic examination on the patient and found hemorrhages and exudate in the eye grounds. I am going to ask Dr. Maurice Schnitker, our present resident physician, to read us what Dr. Peabody wrote when he was resident physician back in 1913.

Dr. Schnitker

This is the Clinical-Pathological Correlation in Dr. Peabody's own words:

"The interest centers around the lungs, heart and kidneys. *Lungs*: 24 hours before death there was noted in the middle of the right back between the spine and the angle of the scapula an area of dullness and rather distant bronchial breathing. The autopsy showed on the posterior and inner surfaces of the lower lobe a dark red area 7 cm. long, 3-5 cm. wide and 2-3 cm. thick. This was demarcated, dark red, and distinctly less crepitant than the surrounding lung tissue. Sections from this area did not sink in water. This was not a definite pneumonia and it is very doubtful whether such an area of congestion

would have given any physical signs were it not that the area was in direct contact with one of the first divisions of the primary bronchus. *Heart:* Associated with the high blood pressure and during life, there was a greatly hypertrophied heart with a forcible heaving impulse. Both sounds at the apex were loud, sharp and rather high pitched. The first sound was followed by a high pitched, musical almost squeaky systolic murmur which was transmitted to the axilla. Pathologically the heart showed great hypertrophy of the left ventricle. There was no dilatation, no myocarditis and clinically there had been little evidence of cardiac failure. The valves were all normal and there was no evidence of dilatation of the mitral ring. It seemed, however, that the systolic murmur at the apex must have been due to a slight regurgitation depending on dilatation or stretching of the mitral ring. At any rate the mitral valve was probably functionally incompetent. The high pitched, loud murmur would be well explained by the strong contraction of the hypertrophied heart muscle and passage of the blood through a very small valvular leak. *Kidneys:* Clinically there was high blood pressure, and the urine, which was usually of almost normal specific gravity (1.015-1.020), contained a trace of albumin and a few hyaline casts. The 'phthalein test was usually much below normal; immediately after bleeding it rose to normal temporarily. The incoagulable nitrogen in the blood was slightly above normal. There was an albuminuric retinitis. Pathologically the kidneys were somewhat smaller than normal. The surfaces were granular and the capsules stripped with slight difficulty. The most important lesions in the gross were marked arteriosclerosis of the smaller vessels in the kidneys. In connection with the high blood pressure, it is interesting to note that there was a marked general arteriosclerosis affecting the smaller vessels throughout the body and especially the smaller vessels of the brain."

Dr. Christian

I am going to ask Dr. Ayer to summarize the post-mortem findings.

Dr. Ayer

The patient was a frail, emaciated, colored woman with no peripheral edema, with no increase in pericardial or peritoneal fluid and with no cerebral edema. Posteriorly and medially in the right lower lobe was a small area of consolidation which was hardly enough to account for death. More striking was the passive congestion of the lungs, liver and spleen and the hypertrophy of the heart which weighed 380 grams.

Histologically the important lesion was the marked arteriosclerosis. In fact the arteriosclerosis was present and marked in every organ examined. However, the most marked vessel changes occurred in the kidneys. Grossly they were small, pale and coarsely granular, weighing 80 grams each. The capsules stripped with slight decortication. On cut surface minute pale scars alternated with deeper red areas in which glomeruli were visible. The larger arteries were thick walled and gaping. Microscopically there was no diffuse increase in connective tissue, this was confined to small wedge shaped areas. Under lower power rare glomeruli were hyalinized, the majority apparently well preserved, but there was an occasional instance of slight capsular proliferation.

Even under low power the thickening of the small arteries and arterioles was prominent. With higher magnification this was more striking but most important were the progressive acute lesions of the afferent arterioles. Necrosis and thrombosis involved loops of tufts at times.

All these changes were noted 25 years ago in the microscopic description, and we see the same today. The diagnosis then was acute and chronic glomerulonephritis. Today it would be rapidly progressing vascular nephritis. Today the absence of generalized increase in the stroma, the presence

of arteriolar sclerosis with necrosis of glomerular loops, and the thickening of the basement membranes of tubules means vascular nephritis, even in the presence of slight proliferation of the capsule of occasional glomeruli.

Dr. Christian

This patient has an opportunity now to make a few remarks.

Dr. O'Hare (the patient)

Ah was full of jubilation
Wen ah got de invitation
To come back to Peter Brigham
Wid de Class of Ten and Free.
But ah muss' confess ah twenbled
Till ma corpse was reassembled
An ah found maself awakin'
In a bed in old Ward E.

Oh, it all seemed quite familiar
In fact was very similar
To de ward ah died back in Free and Ten
Do de nusses hair was shortah
Dey was scurrying as they oughta
To git ready for Perfessor's Rouns at ten.

De perfessor 'gan dictatin'
And now an den oratin'
'Bout Bright's Disease and high blood pressha,
too.
An de docs stood roun' and lissen'
Juss lak Walker, Speck and Sisson.
An' Pebo, Fitz and Dawson use' to do.

Now as ah was leabin' heaben
Last nite bout haf pass 'leben
Massa Brigham stopt me at de Golden Gate,
Sez he, "Tell dose lads and misses
Dat ah sends dem lub and kisses
An ah blesses dere reunion of '38.

Bring to Howland's comprehension
Herbert Howard's new invention
A machine dat does away wid bad accounts,
An Tell Wolbach our decision
To do 'posts' widout incision
Wid de slidin' door contrapshun made by
'Counc'.

Say to surgin Eliot Cutler
Dat he'd better be a butler
Unless he 'dopts de zipper of Monro
Dat will let him in and out, sah,
Quicker'n he can shout, sah,
An 'eliminates all sutures from 3 to triple 0.

Tell dat Massa Henry Chrishin
Dat all of us is wishin'
Dat He'd stay aroun de Brigham for annudder
decade more.

Tell him Rounds would be complete
If each doctor had a seat
An, honestly, ah don't believ dey'd snore.

Say Brights got a new invention
For controllin' hypertension
Malignant or benign he didn' say.
He makes vessels less sclerotic
An' kidneys less nephrotic
By infusions intravenous made ob whey."

Now ah's getting very weary
In troof dis old world's dreary
An ah muss be gitting off without delay.
Cause ah'll lose my job in heaben
If ah don't get back ba seben
An up dere, boys, we aint got no W. P. A.

Dr. Christian

I found it very difficult to figure out how long my various prima donnas would take in the presentation and particularly I was uncertain about these resurrected corpses because I did not myself have any direct communication with Heaven, as yet.

I want to summarize briefly what I might have taken a little longer to tell, namely certain ideas that have been developed in my mind in regard to the old problem of Bright's disease in its various forms. The more I thought about it, the more it seemed to me possible to simplify the situation.

When Bright started out he unified the idea of his disease around a single point, namely the fact that if you boil urine, the protein in it coagulates. He made many observations during life and after death, studied the kidney and demonstrated to his entire satisfaction that the albuminuria was evidence of a diseased kidney. These studies ran from 1827 to 1836 and he reported many of the clinical phenomena that we observe today and to a certain extent interpreted them, but this simplification did not remain.

We find in 1851 that Frerichs looked upon the whole problem of diseased kidney in the Bright's disease sense as merely a progressive stage in the development of the single disease. Soon after that, both in Germany and in England, the idea became existant in the minds of various path-

ologists that not one but many diseases took place in the kidney and that it was not a progress interrupted by death at a particular stage, but a progression of a single disease of the kidney. Finally about 1879 Weigert, in the way he had of clarifying pathological knowledge, carried out this idea of multiplicity of diseases and suggested a classification in a way which isn't very different in its major part from the classification used today, and brought out the idea that a number of changes were taking place in the kidney and that they represented not progression in one disease, but progression in several diseases. From that time on the disease got more and more complex.

I have been wondering if it would be possible to simplify our concept. It seems possible to regard the kidney as an organ not tremendously complicated but as an organ built up of many units, each unit fairly complicated, and the whole kidney a multiplication of these units. That unit is the glomerulus, a network of capillaries connected with larger vessels of the arteriolar type which carry blood first through the glomerulus and subsequently to the basal membrane of the tubules. Now when we come to the pathological changes I think we can reduce them to two in the sense that they deal with this unit, the glomerulus, and these two changes are (1) leakage through the glomerular wall and (2) the progressive increase of throttling down of the circulation by arterioles going

to and from the glomerulus, or by disturbances that take place in the capillaries of the glomerulus. As a result of leakage the urine contains albumin and casts, red cells and to a certain extent pus cells, though that is not an important part of the renal process.

Then throttling gradually brings about two changes. One is a rise in blood pressure, probably directly related to a decreased blood flow through the capillaries. The other is retention of nitrogenous material, which is brought about by the fact that circulation is slowed down through the glomeruli, with the various proliferative processes in the glomeruli and also the throttling process, very often the walls of the capillaries are thickened in various ways and interfere with excretion so that there is nitrogenous retention and uremia. These patients also have secondary changes in the tubules. As a result of all this one may classify Bright's disease very simply on the basis of two processes, the leakage and the throttling in various combinations, the more the throttling the less the leakage and the less the throttling the more the leakage. Consequently the patients with very much albumin have little elevation in blood pressure and the patients with high blood pressure have very slight or moderate leakage of albumin.

We have had a very delightful celebration, I thank every one for coming and particularly I thank my prima donnas for their participation in the program.

TWENTY-FIFTH ANNIVERSARY OF THE PETER BENT BRIGHAM HOSPITAL

From May 5 through May 7 the Peter Bent Brigham Hospital celebrated the twenty-fifth anniversary of its opening. The celebration consisted of a reunion of graduates of the professional and nursing services, demonstrations, ward visits, operations, an extensive program of scien-

tific papers, and various social gatherings. Excerpts from the celebration of the medical service are given in this issue.

On the morning of May 7 a formal public meeting was held beneath a marquee in the space between the hospital and the Medical School. The Right Reverend William Lawrence, Bishop Emeritus of the Episcopal Diocese of Massachusetts gave the invocation. Mr. William Amory

introduced the speakers. General Cole read the address of His Excellency Charles F. Hurley, Governor of the Commonwealth. Dr. Dean Lewis, Professor of Surgery, Johns Hopkins University spoke of the "blood relation" between the Peter Bent Brigham Hospital and the Johns Hopkins Hospital. He mentioned particularly Dr. Cushing who spent some years in the Hopkins Hospital and as a direct result of whose efforts the Hunterian Laboratory of Experimental Surgery, the earliest established in this country, was founded; Dr. Christian, who is a Hopkins graduate; and Dr. Burwell, who was on the medical service of the Hopkins Hospital. President James B. Conant, in felicitating the Hospital on the successful completion of its first twenty-five years, assured the Trustees that the first fifty years of an institution were much the most difficult and were the pioneer years. He spoke of the debt of Harvard University to the hospital and the intimate and cordial interrelationship between the hospital and the Medical School. Dr. Christian gave an inspirational address entitled "A Hospital Comes to Town—The Story of Peter Bent Brigham Hospital in Boston." He quoted Sir Thomas Moore who characterized hospitals as follows, more than four hundred years ago: "These hospitals be so well appointed and with all things necessary to health, so furnished, and moreover, so diligently attended through the continual presence of cunning physicians, that, though no man be sent there against his will, yet, notwithstanding, there is no sick person in all the city that had not rather be there than at home in his own house." The Peter Bent Brigham Hospital

has sent out 158 graduates who have been made professors, associate or assistant professors in medical schools in the United States and in various parts of the world. Among the contributions to medical science by physicians working in the hospital, Dr. Christian enumerated Walter Boothby's studies of metabolism; the development of an effective treatment for pernicious anemia by Dr. Minot and Dr. Murphy (it is of interest, as Dr. Cutler later brought out, that Peter Bent Brigham presumably suffered from pernicious anemia); Cushing's development of safe methods of brain surgery. Dr. Elliott C. Cutler mentioned the fact that if the age of the hospital were reckoned by the Chinese method, from the age of conception, it was celebrating its 60th birthday, for it was over 25 years after Peter Bent Brigham died before "obstetricians" were called upon to deliver the infant. In mentioning the accomplishments of the hospital, Dr. Cutler gave particular praise to the work of the surgeons: Dr. Cushing, Dr. Cheever, Dr. Homans, Dr. Quinby and Dr. Goetsch. Dr. C. Sidney Burwell, employing an analogy from "Alice Through the Looking Glass", called attention to the principle of having to progress in order to remain in the same place. Certain basic traditions have enabled the Brigham Hospital to progress: high standards in the care of patients, the tradition of changing with the times, the pursuit of knowledge, and harmonious relation to Harvard Medical School. Mr. Charles Francis Adams spoke briefly as President of the Community Federation of Boston. The benediction was pronounced by the Right Reverend Francis L. Phelan, chancellor of the Archdiocese of Boston.

List of Hospital Internships, Class of 1938

Name	Hospital	Service	Dates
Abrams, A. L.	Beth Israel, Boston	Surgical	June '38-June '40
Allen, F. H., Jr.	Children's, Boston	Bact. & Path.	Jan. '39-Jan. '40
Allen, J. G.	Univ. Chicago Clinics (Billings) Chicago, Ill.	Surgical	Jan. '39-Jan. '40
Armstrong, W. F.	Starling-Loving, Columbus	Medical	July '38-July '39
Bassett, G. G.	St. Luke's, Cleveland, Ohio	Rotating	July '38-July '39
Beach, N.	University, Minneapolis	Medical	July '38-July '39
Beals, L. S., Jr.	U. S. Navy	Rotating	July '38-July '39
Bengloff, H.	Beth Israel, New York	Surgical	Apr. '39-Apr. '41
Bloomfield, R. A.	Boston City, Boston	II Medical	Jan. '39-July '40
Boger, W. P., Jr.	Philadelphia General, Phila.	Rotating	July '38-July '40
Brewster, H. H.	Massachusetts General, Boston	Medical	July '38-Jan. '41
Brown, L.	Massachusetts General, Boston	Neurosurgery	July '38-Jan. '39
Buermann, A., III	Boston City, Boston	I Surgical	Mar. '39-Mar. '41
Burbank, C. B.	Massachusetts General, Boston	Surgical	Apr. '39-May '41
Cahill, F. P.	Boston City, Boston	II Surgical	Nov. '38-Nov. '40
Campbell, W. N., Jr.	Boston City, Boston	IV Surgical	Mar. '39-Mar. '41
Cappeller, W. S.	St. Luke's, Cleveland, Ohio	Rotating	July '38-July '39
Cary, F. F.	Faulkner Hospital, Jamaica Plain	Rotating	June '38-June '39
Cass, L. J.	Mercy Hospital, Chicago	Rotating	July '38-July '39
Chamberlain, W. B., Jr.	University Hospital of Cleveland (Lakeside)	Medical	June '38-Nov. '39
Coone, H. W.	Cambridge, Cambridge	Rotating	Apr. '39-Oct. '40
Cosby, R. S.	Massachusetts General, Boston	Medical	Apr. '39-Nov. '40
Crane, C.	Peter Bent Brigham-Children's, Boston	Surgical	Mar. '39-Aug. '41
Crawford, G.	Roosevelt, New York	Surgical	July '38-July '41
Cutter, E. P.	Cambridge, Cambridge	Rotating	Jan. '39-July '40
Daly, C.	Fifth Avenue, New York	Rotating	July '38-July '40
Davis, R. F.	Monmouth Mem., Long Branch, N. J.	Rotating	July '38-Jan. '40
Day, E.	Presbyterian, New York	Medical	Oct. '38-Nov. '40
Dee, J. E.	Worcester City, Worcester	Medical	Aug. '38-Aug. '40
Dillon, R. A.	Faulkner, Jamaica Plain	Rotating	Oct. '38-Oct. '39
Dimmler, C. L., Jr.	Peter Bent Brigham-Children's, Boston	Surgical	July '38-Jan. '41
Drane, H. A., Jr.	St. Luke's, Cleveland, Ohio	Rotating	July '38-July '39
Eisman, J. N.	Mt. Sinai, New York City	Medical	Nov. '38-May '41
Epstein, H. C.	University Hospital, Cleveland, Ohio	Rotating-Pediatrics	June '38-July '40
Evans, E. R.	Los Angeles County, Los Angeles	Rotating	July '38-July '40
Evans, R. S.	Boston City, Boston	IV Medical	July '38-Jan. '41
Ferguson, D. H. C., Jr.	Pawtucket Memorial, Pawtucket	Rotating	June '38-Dec. '39
Fields, W. S.	Nashville General, Nashville	Pathological	July '38-July '39
Fletcher, D. B.	Peter Bent Brigham, Boston	Medical	June '38-Feb. '40
Folley, J. H.	Mary Hitchcock Mem., Hanover, N. H.	Rotating	July '38-Dec. '39
Foot, J. J.	Mercy, Springfield, Mass.	Rotating	July '38-July '39
Franke, W. I.	Children's, Boston	Bacteriology	July '38-July '39
Gatto, L. E.	Maine General, Portland	Rotating	Jan. '39-June '40
Gellis, S. S.	New Haven, New Haven	Pediatrics	Sept. '38-Sept. '39
Giddings, W. P.	Massachusetts General, Boston	Surgical	Oct. '38-Nov. '40
Gleuck, B. C., Jr.	Beth Israel, Boston	Surgical	Sept. '38-July '40
Green, DeW. A.	Univ. of Virginia Hosp., Charlottesville	Medical	July '38-July '39
Gruzdiz, V. P.	Newton, Newton, Mass.	Rotating	July '38-July '39
Gummess, G. H.	Boston City, Boston	Pathological	Sept. '38-Feb. '39
Hardy, I. B., Jr.	Massachusetts General, Boston	V Surgical	Mar. '39-Mar. '40
Harrington, P. V.	Worcester City, Worcester	Surgical	Jan. '39-Jan. '41
		Rotating	Jan. '39-Jan. '41

Hartwell, A. S.	Hartford, Hartford	Rotating	July '38-July '40
Hascall, C. S., Jr.	Easton, Easton, Pa.	Rotating	July '38-July '39
Hayden, C. W.	St. Luke's, New York	Surgical	July '38-July '40
Henley, T. F.	Massachusetts General, Boston	Pediatrics	July '38-Apr. '39
Heusner, A. P.	Massachusetts General, Boston	Surgical	Oct. '38-Nov. '40
Hill, J. M.	Maine General, Portland	Mixed	July '38-Jan. '40
Holt, C. L., Jr.	Massachusetts General, Boston	Neurosurgical	July '38-Jan. '39
Hunt, H. H.	University, Ann Arbor, Mich.	Surgical	July '38-July '39
Huntington, B. L.	Massachusetts General, Boston	Medical	Oct. '38-May '40
Hurlbut, R. S.	Massachusetts General, Boston	Surgical	Jan. '39-Feb. '41
Ingersoll, F. McC.	Massachusetts General, Boston	Surgical	July '38-Aug. '40
Irons, E. N.	Peter Bent Brigham, Boston	Medical	Oct. '38-July '40
Jager, B. V.	Boston City, Boston	Pathological	June '38-June '39
Jennison, D. B.	Rhode Island, Providence	Rotating	Sept. '38-Sept. '40
Jewett, J. F.	Pennsylvania, Philadelphia	Rotating	Nov. '38-Nov. '40
Johnson, C. C.	Hartford, Hartford	Rotating	June '38-June '40
Johnson, D. B.	Strong Memorial, Rochester, N. Y.	Surgical	July '38-July '39
Jones, J. E.	Massachusetts General, Boston	Surgical	July '38-Aug. '40
Jones, H. B.	Hartford, Hartford	Rotating	June '38-June '40
Kapnick, I.	Beth Israel, Boston	Surgical	Mar. '39-Dec. '40
Kauppinen, J. A.	Blodgett Memorial, Grand Rapids	Rotating	Sept. '38-Sept. '39
Klopp, C. T.	Palmer Memorial, Boston	Surgical	June '38-June '39
Kneisel, J. J.	Massachusetts General, Boston	Medical	Jan. '39-June '40
Koon, W. D.	Buttersworth, Grand Rapids	Rotating	July '38-July '39
Kopans, D. E.	Beth Israel, Boston	Surgical	Dec. '38-Sept. '40
Lake, F. D.	Springfield, Springfield	Rotating	Jan. '39-July '40
Lancefield, S. M.	Hartford, Hartford	Rotating	June '38-June '40
Leighton, H. T.	Boston City, Boston	II Surgical	July '38-July '40
Lepreau, F. J., Jr.	Mary Hitchcock Mem., Hanover, N. H.	Pathology	June '38-Apr. '39
		Rotating	Apr. '39-Oct. '40
Liebman, S. D.	Beth Israel, Boston	Medical	Apr. '39-July '40
Lloyd, W. J.	Rochester General, Rochester, N. Y.	Medical	July '38-July '39
Lorimer, R. V.	Boston City, Boston	III Surgical	Nov. '38-Nov. '40
Mabon, R. F.	Grady Hospital, Atlanta, Ga.	Rotating	June '38-June '39
MacLaren, W. R.	Massachusetts General, Boston	Pediatrics	Jan. '39-Oct. '39
Maier, J.	Massachusetts General, Boston	Medical	July '38-Feb. '40
Mangels, M., Jr.	Roosevelt, New York	Surgical	July '38-July '41
McKell, D. McC., Jr.	Palmer Memorial, Boston	Surgical	July '38-July '39
Mead, S.	Massachusetts General, Boston	Medical	Oct. '38-May '40
Merrill, B. R.	Univ. Cal. Hosp., San Francisco	Medical	June '38-June '39
Migel, D.	Springfield, Springfield	Rotating	Jan. '39-June '40
Miller, G. F.	Boston City, Boston	III Surgical	Mar. '39-Mar. '41
Moore, B. E.	Vanderbilt Univ., Nashville, Tenn.	Medical	July '38-July '39
Moore, P. T.	U. S. Public Health Service	Rotating	July '38-July '39
	Stapleton, Staten Island		
Nelson, J.	Bellevue, New York, 4th Div.	Medical	July '38-Jan. '40
Nies, R. D.	Philadelphia General, Philadelphia	Rotating	July '38-July '40
O'Brien, W. H.	Albany, Albany, N. Y.	Rotating	July '38-July '39
Oliver, E. B.	Springfield, Springfield	Rotating	July '38-Jan. '40
Owens, R. R.	Presbyterian, Chicago	Mixed	Mar. '38-July '39
Pyles, W. J.	Presbyterian, New York	Pathological	June '38-July '39
Rambo, R. R.	U. S. Navy Hospital	Rotating	July '38-July '39
Rice, T. A.	Worcester City, Worcester	Rotating	Mar. '39-Mar. '41
Riley, C. M.	Presbyterian, New York	Medical	Oct. '38-Nov. '40
Rizer, D. K.	Peter Bent Brigham-Children's, Boston	Surgical	Sept. '38-Mar. '41
Robinson, C. A.	Roosevelt, New York	Surgical	Jan. '39-Jan. '42
Rosenow, J. H.	Univ. of Minnesota, Minn.	Pathological	July '38-Jan. '39
	Presbyterian, Chicago	Combined	Mar. '39-Nov. '40
Ross, D. A.	McGill U., Montreal, Dept. Physiology	Lecturer	Aug. 38-

Rumsey, W. L., Jr.	Lenox Hill, New York	Mixed-Ped.	Jan. '39-Jan. '41
Russell, H. N.	Charles Chapin, Providence	Contagious	Oct. '38-Apr. '39
	Massachusetts General, Boston	Pediatrics	Apr. '39-Jan. '40
Schneider, A. B., Jr.	Peter Bent Brigham, Boston	Medical	Oct. '38-June '40
Schumann, W. R., Jr.	Los Angeles County, Los Angeles	Rotating	July '38-July '40
Seeler, A. O.	Memorial, Worcester	Rotating	July '38-Mar. '40
Sise, H. S.	Boston City, Boston	IV Medical	Apr. '39-Oct. '40
Skinner, D.	Newton, Newton, Mass.	Rotating	July '38-July '39
Smith, E. L., II	Rhode Island, Providence	Rotating	Oct. '38-Oct. '40
Smith, R. M.	Faulkner, Jamaica Plain	Rotating	June '38-June '39
Stenzel, F. R.	Newton, Newton, Mass.	Rotating	July '38-July '39
Strobino, L. J.	Springfield, Springfield	Rotating	Jan. '39-July '40
Swann, W. K.	Boston City, Boston	V Surgical	July '38-July '40
Tatlock, H.	Massachusetts General, Boston	Medical	Apr. '39-Nov. '40
Thomson, R. S.	Long Island Col. Hosp., Brooklyn	Surgical	July '38-July '39
Tucker, R. P.	Massachusetts General, Boston	Surgical	Apr. '39-May '41
Turner, E. V.	New Haven, New Haven	Pediatrics	July '38-July '39
Turner, T. E.	Memorial, Syracuse, N. Y.	Rotating	July '38-July '40
Twitchell, M. C.	Mary Fletcher, Burlington, Vt.	Rotating	July '38-July '39
Upjohn, R. H.	Mary Imogene Bassett Hosp., Cooperstown, N. Y.	Mixed Medical	July '38-July '39
Walker, W. H.	Boston City, Boston	II Medical	Oct. '38-Apr. '40
Weisel, L. W.	St. Joseph's, Milwaukee, Wis.	Mixed	July '38-July '39
Wells, G. R.	Pennsylvania, Philadelphia	Rotating	Sept. '38-Sept. '40
Weston, J. I.	Rhode Island, Providence	Rotating	Mar. '39-Mar. '41
Wilder, R. M., Jr.	Univ. Chicago Clinics, Chicago	Medical	Oct. '38-Oct. '39
Wilkinson, A. W.	St. Luke's, Chicago	Rotating	July '38-July '39
Yankauer, A., Jr.	Albany, Albany, N. Y.	Rotating	July '38-July '39

HENRY ASBURY CHRISTIAN PRIZE OF THE HARVARD MEDICAL SCHOOL

On February 17, 1938, at one of the luncheon Colloquia held at Vanderbilt Hall, the first Henry Asbury Christian Prize was awarded. This prize has been founded by Samuel A. Levine, '14, in honor of Dr. Christian. It is to be awarded to a member of the Senior Class of the Harvard Medical School who has been deemed by competent authority to have "displayed diligence and notable scholarship in his studies and offers promise for the future."

This year the prize went to Mr. John Maier, of Royersford, Pennsylvania. Dr. Christian presented the award in the form of a sum of money and in addition two volumes from his personal library containing original papers from Robert Koch's library.

CLASS OF 1901

An informal meeting and dinner of the local members of the Class was held at the Harvard Club of Boston on May 20. The class president, David Cheever, presided and 29 members were present. The success of the meeting was shown by the fact that the members voted to have dinners annually in future instead of once in five years as heretofore.

HONOR FOR DR. RUSSELL

Dr. Frederick F. Russell, professor of Preventive Medicine and Epidemiology at the Harvard Medical School, has received the Buchanan Medal of the Royal Society of London, England, in recognition of "his world wide services in the development of public health."

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Clark W. Heath

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Marshall K. Bartlett

*Room 111, Harvard Medical School
 Boston, Mass.*

SECRETARY'S REPORT

Three meetings of the officers and council of the Harvard Medical Alumni Association were held during the year. The following business was transacted during these meetings. \$500 was added to the Fund for the benefit of needy students faced with larger hospital bills, the total being raised to \$1,000. It was decided that the Association should endeavor to keep the fund at this level by annual donations. In addition, \$50 was placed at the disposal of the Physician to Students to pay for small medical bills incurred by poor students.

The Association sponsored a dinner for Alumni during the Annual Meeting of the American Medical Association which took place in June in San Francisco.

The Alumni Association gave a dinner to the Graduating class of the Medical School on May 26 at Vanderbilt Hall. The speakers were President Lincoln Davis, toastmaster, C. Sidney Burwell, Henry Christian, Mr. Francis Ingersoll, president of the class, Lloyd Brown, representing the seven alumni who had sons in the class, Frederic W. Washburn and Richard O'Neil.

Three new councillors were elected at the annual meeting. A full report of this meeting is published in this issue.

Respectfully submitted,
 CLARK W. HEATH, M.D.,
Secretary.

MEDICAL SEMINAR IN CHICAGO

The program of the Medical Seminar, at the Meeting of the Associated Harvard Clubs, was held in Chicago, on the afternoon of Saturday, May 21. The program began with a paper by Dean C. Sidney Burwell on "The Harvard Medical School in 1938." He reported the recent additions to the Faculty, and spoke of the various problems which confronted the Admission Committee in the selection of the students, particularly its efforts to select students of superior character, personality, and intellectual equipment. Dr. A. Baird Hastings, of the Department of Biological Chemistry, then presented a paper on "Trends in Preclinical Teaching" wherein he related the efforts being made to correlate the teaching in the preclinical sciences with the teaching in the clinical years. Dr. Walter Bauer, of the Department of Medicine, gave a paper on the history of the tutorial system, showing the advantage that it had been to numerous students in providing them with an opportunity to develop independence of thought and experience in research. Dr. Elliott C. Cutler, of the Department of Surgery, closed the formal program with a paper on "The Surgical Curriculum of Today." He laid particular emphasis on the undergraduate training of the medical students, pointing out that the Department of Surgery is responsible for education in: (1) anesthesia, and (2), the proper care of trauma and infection, which play such a large role in the work of the general practitioner. The four papers were then discussed by several members of the medical profession who had been invited to attend the symposium. The discussion was opened by Dr. Joseph T. Wearn, Professor of Medicine at Western Reserve University. Dr. Wearn made

a special plea in his discussion to use every effort in the selection of medical students of good character and broad interests. Dr. Wearn was followed by Professor Blankenhorn of Cincinnati, and Drs. Wilder and Balfour of the Mayo Clinic, and Dr. Dick, Professor of Medicine at the University of Chicago. The meeting was excellently attended, there being approximately two hundred people in the audience, including representatives from many of the medical schools in the vicinity of Chicago. Dr. W. O. Thompson was in charge of the arrangements.

ANNUAL MEETING

The annual meeting of the Harvard Medical Alumni Association was held on May 31 at the Hotel Bradford, Boston. President Lincoln Davis, '98, was chairman. The following new members of the Council were elected by unanimous ballot: W. Richard Ohler, '14; Francis C. Newton, '19; and Frederick S. Hopkins, '18. The following three members of the Council are retiring: Augustus Thorndike, Jr., '21, Harrison B. Chase, '05, and Ralph W. French, '10.

It was voted that the Association approves the action of the Council in sponsoring an annual dinner for the graduating class of the Medical School.

Dean Burwell was the chief speaker. He outlined some of the progress and policy of the Medical School. Great care is being taken by the Committee on Admissions to select superior students of diverse interest. About one-half of the students admitted have had A or B marks in college. But many men with good marks are not admitted because their recommendations are not satisfactory. About 10 per cent of each class is admitted without a bachelor degree. That this procedure is not unwise is shown by the fact that the students without bachelor degrees do better work scholastically than the others. They are, of course, selected with extreme care. Dr. Burwell reported strong interest in the welfare of the Medi-

cal School on the part of alumni in various parts of the country. He was particularly impressed by the interest shown at the recent Seminar in Medical Education at Chicago. (See report in this issue). Dr. Burwell summarized what must be his credo in good medical education in the following four points: (1) a superior student body; (2) a superior faculty body; (3) teaching by example more than by precept; (4) the provision of extraordinary opportunity for study and work.

HENRY B. MARTIN



Henry B. Martin, who was in charge of the students' laboratory of the Department of Biological Chemistry since 1896, died suddenly at his home in Arlington Heights on June 1.

At their first encounter with him, most students were alarmed by the gruff and forbidding exterior which Henry loved to put forward to each new acquaintance. As time went on, however, students found



